CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 19.1
TITLE: MUSCULOSKELETAL SYSTEM

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

I. EFFECTIVE DATE

A. August 26, 1985

B. August 25, 1997, for autologous chondrocyte implantation (ACI).

C. December 11, 1986, for anterior cruciate ligament repair.

D. October 1, 1993, for endoscopic release of the transverse carpal ligament.

II. PROCEDURE CODE(S)

11730-11732, 20000-22505, 22548-29902, 63075-63078, and 73620

II. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

III. POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered.

IV. POLICY CONSIDERATIONS

A. Joint Injections.

1. Arthrocentesis, aspiration or injection (CPT codes 20600-20610) are reimbursed as follows:

a. only one injection per joint is covered on the same day,

b. multiple joints injected will be reimbursed at 100% of the allowance for each joint, up to three joints, and

c. each joint injected more than three times will be reimbursed at 50% of the allowance for each.

2. Therapeutic injections of the same joint are limited to a maximum of two per month for three months. Further payment for injections into the same joint within six months requires documentation and medical review.

3. Daily aspirations of infected joints may be paid for a maximum of five days. The medical necessity for further aspiration on a daily basis must be documented for medical review.

B. Aspiration of Joint/Closed Reduction of Fracture. When aspiration of a joint is performed in conjunction with a closed reduction of a fracture of joint, reimbursement will be 100% of the allowance for the closed reduction, and 50% of the allowance for the aspiration. When the aspiration is performed on a day subsequent to closed reduction of a joint, reimbursement for the aspiration will be 100% of the allowance.

C. Treatment of Fracture-Inpatient:

1. application and removal of the initial cast,

2. traction,

3. suturing of the skin, and

4. uncomplicated follow-up visits.

D. Treatment of Fracture-Outpatient. Reimbursement for treatment of simple or compound fracture, by closed or open methods, performed on an outpatient basis includes the following and no separate payment may be made:

1. reduction, where indicated,

2. pin, wire, metal band, screw (insertion),

3. simple repair of wound,

4. application and removal of a cast, and

5. uncomplicated follow-up office visits.

E. Multiple Fractures Requiring Surgery. Surgical procedures, closed or open, performed in the treatment of multiple fractures, will be reimbursed at 100% of the allowance for the procedure with the highest value and 50% of the allowance for the procedure with the lesser value.

F. Reduction or Repair of Fractured or Dislocated Digit. A surgical procedure for the reduction of a fractured or dislocated digit with soft tissue closure, or the repair of a compound or comminuted fracture of the digit includes the removal of the nail and repair of the laceration with the fractured digit.

G. Removal of Nail/Closed Reduction. The removal of a finger or toenail (CPT codes 11730-11732) when performed in conjunction with a closed reduction of a digit is reimbursed at 50% for the procedure.

H. Second Reduction-Same Surgeon. A surgical procedure performed as a second reduction of a previously reduced fracture, by the same physician, is reimbursed at 100% of the allowance, provided the second reduction (open or closed) is performed under general or regional anesthesia, and on a day subsequent to the initial reduction. Additional reduction performed by this same physician is reimbursed at 50% of the allowance.

I. Second Reduction-Different Surgeon. A surgical procedure performed as a second reduction of a previously reduced fracture, by a physician other than the physician performing the initial reduction, is reimbursed at 100% of the allowance regardless of the date of the original reduction or the number of reductions performed by the initial physician prior to this procedure. Additional reductions performed by this different physician are reimbursed at 50% of the allowance.

J. Hospital Visits for Complications. Hospital visits, pre- or postoperative, may be covered for the care of complications. These claims require documentation as to medical necessity, level of care rendered, and procedures performed, for medical review.

K. Cast Applied After Initial Cast. A cast applied subsequent to the initial cast, in the office or in the hospital, is covered. The allowance includes reimbursement for the application of the cast and the cost of the cast supplies.

L. Cast Removal. Cast removal is included in the initial allowance for application of the cast. In instances where the cast was applied in one geographical location and the removal must be done in another geographical location, a separate benefit payment may be provided for the removal. Benefits are not available for the services of a second provider if those services could have reasonably been rendered by the provider who initially applied the cast.

M. Windowing of a cast. The application of a cast, to include windowing, and removal of the cast is usually included in the evaluation and management charges. However, the windowing of a cast (CPT code 29730) may be cost shared as a separate procedure when the procedure is performed on a different date as the primary procedure.

N. Office Visits During Follow-up Period. Routine office visits related to fracture care are not covered when rendered by the primary physician during the specified follow-up period, the extent of which is generally based upon local practice.

O. Incision and Drainage. Incision and drainage procedures related to the reduction of a fracture are not considered routine fracture care and are covered, beginning 72 hours after the procedure. Services provided during the first 72 hours are considered incidental to the reduction and included in the global fee.

P. X-Rays. X-rays, including interpretations, are covered only when disease or injury is present or suspected. Payment is made in addition to the allowance for the surgical procedure. An x-ray of the foot not specified as to the number of views should be classified as "radiologic examination, foot; anteroposterior and lateral views" (CPT code 73620).

Q. Comparison X-Rays. X-ray views taken of the part of the body contralateral to the affected area may be indicated in cases of developmental abnormality or of trauma to children. Payment should be made for a "limited" x-ray series of the contralateral part when comparison x-rays are billed. If comparison x-rays are billed at a level above "limited," the claim should be referred to medical review.

R. Hammer Toe Surgery.

1. Correction of "Hammer Toe" (CPT codes 28285-28286) is a covered surgical procedure and is reimbursed in addition to a tenotomy when performed through separate incisions. If more than one tenotomy is done through the same incision during the same operative session, reimbursement will be made for only one tenotomy.

2. An operative report is required for all hammer toe surgery. The report must include:

a. indications for surgery,

b. findings at surgery, and

c. operative technique.

S. Surgical Implant Devices. Surgical implant devices are covered and reimbursed at actual cost as shown by an invoice. Payment may be made to the hospital where the surgery was performed or to the provider (or beneficiary), if the cost of the device represents an out-of-pocket expense. The surgical implant must be approved by the Food and Drug Administration (FDA).

T. Treatment of "Flat Foot" Conditions.

1. The following services for treatment of flat feet are not covered:

a. treatment of pes planus (flat feet), and

b. correction of subluxation (flat feet, surgical or non-surgical).

NOTE: Treatment of subluxation of the foot should not be confused with treatment of an acute dislocation of the foot.

2. Medically necessary and appropriate corrective foot surgery for flat feet with induced or associated symptomatic condition may be covered on a case-by-case basis.

U. Bunionectomy.

1. Bunionectomy is covered and paid at different levels, as follows:

a. simple (Silver procedure) (CPT code 28290),

b. modified (Keller, McBride or Mayo type procedure) (CPT code 28292-29293), and

c. radical (Joplin procedure) (CPT code 28294).

d. Mitchell procedure (CPT code 28296).

e. Lapidus procedure (CPT code 28297).

f. phalanx osteotomy (CPT codes 28298 and 28299).

2. Bunionectomy, if the level is not identified, is classified as "simple" (CPT code 28290).

V. Tendon-Lengthening Procedures.

1. Tendon-lengthening procedures or tenotomes of the extensor tendons (CPT 28234) are included in the reimbursement for a bunionectomy, metatarsophalangeal joint, or metatarsal procedures. Tendon lengthening or tenotomy of the flexor tendon is covered during these procedures only if a separate incision is made.

2. Tenotomes for claw toes, asymptomatic or passively correctable are not covered.

3. Tendon-lengthening procedures or tenotomy, when performed on two adjacent tendons are reimbursed as one procedure.

4. An operative report is required for all tendon-lengthening procedures.

W. Insertion of Joint Prosthesis. An additional professional allowance may be made for insertion of a joint prosthesis in the metatarsophalangeal joint. The additional allowance will not exceed two allowances per foot.

X. Subungual Ostectomy. A subungual ostectomy is a covered service and reimbursement includes allowance for removal of the toenail or matrix of the nail. A subungual ostectomy is classified as "ostectomy of a digit, toe."

Y. Sesamoidectomy. A sesamoidectomy is a covered service only when not performed in conjunction with other foot surgery.

Z. Anterior Cruciate Ligament Repair. Repair of the anterior cruciate ligament by arthroscopically assisted surgery will be paid at the same level for the open surgical procedure. For patients who have had at least one failed autogenous intra articular reconstruction of the anterior cruciate ligament, implantation of the polytetraflouro-ethylene ligament (Gore-Tex) approved by the FDA is eligible for payment.

AA. Endoscopic release of the Transverse Carpal Ligament.

1. Endoscopic release of the transverse carpal ligament (29848) is a HAC benefit. Reimbursement for the procedure is limited to the total CHAMPVA Maximum Allowable Charge.

2. Endoscopic release is limited to one procedure per wrist. Repeat endoscopic release is not covered.

3. Endoscopic release is covered only for treatment of patients whose documented signs and symptoms of carpal tunnel syndrome (CTS) have not responded to a minimum of six weeks conservative therapy to include:

a. splints,

b. nonsteroidal anti-inflammatory drugs, and/or

c. change of activities that produce CTS symptoms.

4. Contraindications. Endoscopic release of the transverse carpal ligament is excluded as a benefit when the otherwise qualified patient has any of the following:

a. previous carpal tunnel surgery,

b. previous surgery or concurrent medical conditions that preclude full extension of the involved wrist,

c. rheumatoid tendonitis of the involved wrist, or

d. space-occupying lesion(s) in the involved carpal tunnel.

5. Endoscopic performance of any of the following procedures in the wrist is excluded:

a. tenosynovectomy,

b. neurolysis,

c. Z-plasty,

d. carpal ligament repair, or

e. release of Guyon's canal.

BB. Autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the Food and Drug Administration.

CC. Muscle transfer performed to correct abnormalities of the eye, face, hands or feet resulting from Moebius Syndrome.

DD. Single or multilevel anterior cervical microdiskectomy with allogenic or autogenic iliac crest grafting and anterior planting is covered for the treatment of cervical spondylosis.

V. EXCLUSIONS

A. Prolotherapy.

B. Joint sclerotherapy.

C. Ligamentous injection with sclerosing agents.

D. Percutaneous vertebroplasty (CPT Codes 22520-22522).

END OF POLICY